



Massachusetts Department of Environmental Protection  
Bureau of Waste Prevention

# Toxics Use Fee Worksheet

Reporting Year \_\_\_\_\_

Facility Name \_\_\_\_\_

DEP Facility ID Number \_\_\_\_\_

**Important:**

When filling out forms on the computer, use only the tab key to move your cursor - do not use the return key.



a. Facility Name \_\_\_\_\_

b. Facility Site Address \_\_\_\_\_

c. City \_\_\_\_\_

MA

d. State \_\_\_\_\_

e. Zip Code \_\_\_\_\_

The amount of your fee depends on the number of "full time employee equivalents" (2,000 work hours per year) at your facility, and the number of toxic substances for which reporting is required (i.e., the number of Form Ss you submit).

Use the following schedule to determine your fee for the \_\_\_\_\_ reporting year.

# Full Time Employee Equivalents	Base Fee	Maximum Fee
$\geq 10$ and $< 50$	\$1,850	\$5,550
$\geq 50$ and $< 100$	\$2,775	\$7,400
$\geq 100$ and $< 500$	\$4,625	\$14,800
$\geq 500$	\$9,250	\$31,450

Determine your base fee by referring to the 2nd column above.

\$

f. \_\_\_\_\_

Enter # of Form Ss you are filing:

g. \_\_\_\_\_

Multiply LINE g by \$1,100.

\$

h. \_\_\_\_\_

Add LINE f and LINE h.

\$

i. \_\_\_\_\_

Enter the amount from LINE i or from the 3rd column of the schedule (Maximum Fee) WHICHEVER IS LESS

\$

j. \_\_\_\_\_

Your fee is the amount entered in LINE j. DO NOT SEND YOUR PAYMENT with your toxics use report. DEP will send a bill in the amount owed after receipt of your report. **Payment is DUE 30 days after your receipt of the billing document.**

I hereby certify that I have reviewed this and all attached documents and that, to the best of my knowledge and belief, the submitted information is true and complete and that the amounts and information in this and related documents are accurate based upon measurement and/or personnel records. I agree on behalf of the filing company, to remit the required Toxics Use Fee as determined in Line j (above) to the Commonwealth of Massachusetts as required by 301 CMR 40.03. I further certify that the information contained within this filing is true and accurate pertaining to the TURA Billing Information Form.

k. Signed under pains of perjury by an authorized company representative \_\_\_\_\_

l. Date (mm/dd/yyyy) \_\_\_\_\_